2 IN THE STATE OF ARIZONA 3 In the Matter of Board Case No. MD-99-0579 4 Inv. No. 13063 **ENRIQUE SUAREZ. M.D.** 5 FINDINGS OF FACT. Holder of License No. 8057 6 **CONCLUSIONS OF LAW** For the Practice of Medicine AND ORDER In the State of Arizona. 7 (Decree of Censure) 8 This matter was considered by the Arizona Board of Medical Examiners ("Board") 9 at its public meeting on August 16, 2001. Enrique Suarez, M.D., ("Respondent") 10 appeared before the Board, without legal counsel, for a formal interview pursuant to the 11 authority vested in the Board by A.R.S. § 32-1451(I). After due consideration of the facts 12 13 and law applicable to this matter, the Board voted to issue the following findings of fact, 14 conclusions of law and order. 15 FINDINGS OF FACT 16 The Board is the duly constituted authority for the regulation and control of 1. 17 the practice of allopathic medicine in the State of Arizona. 18 Respondent is the holder of License No. 8057 for the practice of medicine 2. 19 in the State of Arizona. 20 Respondent was an employee of the Arizona Department of Corrections 3. 21 ("Department") until February 18, 1999 when he was placed on administrative leave. 22 Respondent later resigned his position in lieu of termination. 23 In June of 1998, an inmate ("Patient") presented to Respondent for the first 4. 24 time. Thereafter, Patient saw Respondent occasionally. On December 8, 1998, Patient 25 presented to Respondent and complained of night chills, loss of appetite, shortness of

BEFORE THE BOARD OF MEDICAL EXAMINERS

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breath and severe headaches. CBCs and ABG's were done on Patient and HIV testing was ordered, but no evidence was found that it was done.

- 5. From December 8, 1998 through December 14, 1998, there was no medical intervention on behalf of Patient.
- 6. On December 15, 1998, a chest x-ray was taken of Patient. The x-ray taken on December 15, 1998, showed a right mid-lung infiltrate. Patient's records indicate that Respondent did not look at the chest x-ray on this date. On December 17, 1998, Patient's pulse oximetry was seventy-five percent and he was weak. Patient had lost six pounds in 9 days.
- 7. Respondent did not hospitalize Patient and Patient was returned to his housing unit. Respondent requested an internal medicine consultation with a priority index of "3".
- 8. On December 18, 1998, a bed check found Patient on the floor, unconscious, with a temperature of 102 degrees, pale in color, diaphoretic. Patient had lost ten pounds since December 8, 1998.
- 9. Patient was transferred to St. Mary's Hospital. On December 21, 1998, Patient had respiratory arrest and was pronounced brain dead. Patient later died on this same day. The cause of death was determined to be complications associated with Acquired Immune Deficiency Disorder.
- 10. Patient's Department medical file indicates there was a time delay from when diagnostic tests were ordered for Patient, when they occurred and when the results were made known to Respondent.
- 11. Respondent failed to record vital signs, such as respirations and presentation of symptoms on Patient's medical chart.

12. Patient's records suggest that Respondent delayed in providing for or arranging for the necessary diagnostic tests and Respondent failed to follow Department policy requiring him to first read x-rays on the day they are taken and then forward the x-rays to a radiologist for a final reading.

- 13. At the formal interview before the Board, Respondent maintained that a priority index of "3" means that an inmate should be seen as soon as possible without going through the channels. Respondent could not explain priority index "1" and "2".
- 14. The records before the Board indicate that priority index "3" is an average consult, routine, not emergent.
- 15. Respondent failed to recognize that Patient was critically ill, failed to provide aggressive evaluation and treatment, and maintained sparse medical records on Patient.
- 16. Respondent maintained that a Peer Review conducted regarding his care of Patient "cleared" him of any wrongdoing. The records before the Board indicate that Respondent was not "cleared" by the Peer Review.

CONCLUSIONS OF LAW

- 1. The Board of Medical Examiners of the State of Arizona possesses iurisdiction over the subject matter hereof and over Respondent.
- 2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.
- 3. The conduct and circumstances above in paragraphs 4, 6, 7, and 11 through 16 constitute unprofessional conduct pursuant to A.R.S. § 32-1401 (25)(q) "[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public."

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ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED that Respondent is issued a Decree of Censure for failing to recognize, evaluate and treat a critically ill patient.

RIGHT TO PETITION FOR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing. Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing must be filed with the Board's Executive Director within thirty (30) days after service of this Order and pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a rehearing. Service of this order is effective five (5) days after date of mailing. If a motion for rehearing is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing is required to preserve any rights of appeal to the Superior Court.

BOARD OF MEDICAL EXAMINERS

OF THE STATE OF ARIZONA

CLAUDIA FOUTZ

Executive Director

DATED this and day of October, 2001.

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ORIGINAL of the foregoing filed this 12 day of <u>October</u>, 2001 with:

The Arizona Board of Medical Examiners 9545 East Doubletree Ranch Road Scottsdale, Arizona 85258

1	Executed copy of the foregoing mailed by U.S. Certified Mail this
2	12_ day of <u>October</u> , 2001, to:
3	Enrique Suarez, M.D.
4	2685 West Calle Cuero DeVala Tucson, Arizona 85745-3565
5	Copy of the foregoing hand-delivered this
6	12 day of <u>October</u> , 2001, to:
7	Christine Cassetta Assistant Attorney General
8	Sandra Waitt, Management Analyst
9	Lynda Mottram, Compliance Officer Lisa Maxie-Mullins, Legal Coordinator (Investigation File)
10	Arizona Board of Medical Examiners 9545 East Doubletree Ranch Road
11	Scottsdale, Arizona 85258
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